

## DCAP CHANGE IN STATUS FORM

for FY \_\_\_\_\_

### Section 1 – Employee Information

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First

\_\_\_\_\_  
Initial

### Section 2 – Type of Transaction

A Change in Status which is **on account of and consistent with the nature of the qualifying event** must occur in order to change your current DCAP account. Requests to change your deduction amount or revoke your enrollment must be initiated within 60 days of the qualifying event. Changes in Status indicated with an “\*” must be reviewed and approved by the FSA Unit on a case-by-case basis. You may contact the FSA Unit at 1-800-442-1300 if you have any questions.

☐ **Increase in Deduction Amount**      Change in Status Code \_\_\_\_\_      New Deduction Amount Per Pay Period \$ \_\_\_\_\_

01	Adoption of dependent *
02	Marriage
03	Divorce, legal separation or annulment *
08	Judgment, decree or court order *

14	Spouse commences employment
18	Spouse changes employment status from Part-time to Full-time
21	Change in the cost of care
24	Coordination of spouse's annual benefit election period

☐ **Decrease in Deduction Amount**      Change in Status Code \_\_\_\_\_      New Deduction Amount Per Pay Period \$ \_\_\_\_\_

03	Divorce, legal separation or annulment *
04	Death of dependent *
05	Dependent becomes ineligible (e.g. age)
08	Judgment, decree or court order *

17	Spouse changes employment status from Full-time to Part-time
21	Change in the cost of care
24	Coordination of spouse's annual benefit election period

☐ **Revocation of Enrollment**      Change in Status Code \_\_\_\_\_

03	Divorce, legal separation or annulment *
04	Death of only dependent
05	Dependent becomes ineligible
08	Judgment, decree or court order *
12	Employee changes employment status from Full-time to Part-time less working than 50%

15	Spouse terminates employment
19	Employee enters leave of absence
20	Spouse enters leave of absence
21	Change in the cost of care
22	Employee termination of employment, retirement or death
24	Coordination of spouse's annual benefit election period

### Section 3 – Certification

I certify that the above eligible change in status event occurred on \_\_\_\_/\_\_\_\_/\_\_\_\_.

Employee Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

### Section 4 – Agency Approval (To be completed by Group Insurance Representative)

GIR Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

#### GIR INSTRUCTIONS

- Forward the original to the FSA Unit at CMS and retain one copy of the form in the member's file.

**Return the completed form to your Group Insurance Representative**